

ACUTE CARE RFP YH09-0001 QUESTIONS AND RESPONSES 3/14/08

Question #	Section	Paragraph	Page Number	Question	Answer
1	D	38	67	The RFP states "Additionally, unless a shorter time period is specified in the contract, the Contractor shall not pay a claim initially submitted more than 6 months after date of service or pay a clean claim submitted more than 12 months after the date of service." If a Provider submits a claim within 6 months that is not clean, do they have 12 months to submit a clean claim?	In this scenario, the provider would have up to 12 months from the date of service or eligibility posting, whichever is later, to submit a clean claim.
2	Instructions to Offers	n/a	125	This standard (#25 – “describe planned and existing disease/chronic care management programs...”) is significant and we would like to give a full answer. Can we exceed 3 pages for this limit? Perhaps extend to 5 pages?	No. The response is limited to three pages.
3	Bidder's Library			The revised Attestation Statement shows that Hospitals are required in San Luis (Yuma County) and Williams (Coconino County). Hospitals do not exist in either town. Please clarify.	The Attestation has been updated to reflect the correct requirement.
4	B		121	There is no specialty code for Urgent Care. What specialty code should be used for these providers?	The State of Arizona does not recognize Urgent Care as a provider type they are considered to be provider offices. Offeror's should only list the Provider's specialty codes.
5	B		121	If a provider has no middle name, would you like the name format to be Smith/Joseph/ or Smith/Joseph	Please list providers without Middle names as Smith/Joseph.
6	B		121	If a Physicians Assistant is contracted to provide family medicine services, should the PA specialty code, the family medicine specialty code, or both be entered?	An AHCCCS registered Physician Assistant can only have a specialty code of 798 (physician assistant) regardless of services provided.

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7	Data Supplement		2	For the outlier methodology, are the estimates based on payments to facilities, rather than based upon payments on behalf of members?	Estimates are based on payments to facilities using actual member encounter data.
8	Data Supplement		4	Is the reinsurance table reflecting 75% coinsurance for 2008-2009 for regular reinsurance, not for catastrophic or transplant which have different coinsurance values?	AHCCCS cannot pinpoint the table you are referring to as a Section of the Data Supplement was not listed. However, 75% is the coinsurance for Prospective Regular Reinsurance cases only.
9	I	Network	121	Network Attestation – access to care patterns for Pinal County residents in some areas involve providers in northern Pima County. Since Pima is not listed as a community under GSA 8, are we permitted to add Pima as a community to list those providers? And if yes, are there any specific guidelines you wish us to follow?	No, the Offeror may not amend the attestation. However, if the Offeror has providers practicing in GSA's other than those being bid, the provider may be included as part of the network listed on the CYE '09 RFP Minimum Network Standards Excel Spreadsheet located in the Bidder's Library. The Offeror must list the provider in the GSA that the member that they are contracted to treat reside. For example, a provider practicing in GSA 8 that is contracted to treat members in GSA 10 should be listed on the GSA 10 Spreadsheet.
10	I	Network	121	Network Attestation – are we to include blank grids for the GSAs that we are not bidding or only include those grids for GSAs being bid?	Please only submit Attestations for the GSAs being bid.
11	Data Supplement for Offerors	NA	NA	Does the State include PPC counts in any of the provided enrollment data, H-1 through H-6? If so can those numbers be broken-out on their own schedule by cohort, so that we can determine what impact PPC enrolment has on the total bid amount? If the information cannot be broken-out, can the state approximate the percentage of PPC membership by cohort?	The enrollment data includes Propsective enrollment only. PPC enrollment should not have an impact on your bid amount as the bid amounts are for Prospective enrollment only.

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12	Data Supplement for Offerors	NA	NA	Are the enrollment numbers in Attachment H-1 inclusive of KC and HIFA members as well as TANF? If so, can the State provide a schedule of enrollment with the cohorts separated so that we may see true TANF enrollment counts?	TANF rates are set by combining the KC and HIFA members with the TANF members where applicable. The information requested may be found at http://www.azahcccs.gov/Statistics/AHCCCSpopulation/2008/Feb/default.asp
13	IV. Program Question 13		124	What are the current State/EQRO PIPs and what PIPs are being considered in the review which will follow?	PIPs currently mandated by the State for Acute-care Contractors are: 1) Asthma Management and 2) Physician Reporting to ASIIS. These PIPs include only current Contractors. A State-mandated PIP for CYE 2009 has not been selected yet.
14	V Organization Question 54		129	With respect to "Describe the Offerors HIPAA version migration plans...", in light of other compliance dates that have passed with compliance realized, are there particular standards the agency would like to see addressed?	Not specifically at this time. The intent is to demonstrate how future CMS mandates such as implementation of 5010 versions, ICD10 coding, etc will be realized.
15	IV. Program Behavioral Health		126	What specifically is the role of the behavioral health contractor? Will it include coordinating services for SPMI & SED?	AHCCCS is assuming that the Offeror is meaning the "behavioral health contractor" to be the Offeror. The Offeror is responsible for ensuring and coordinating behavioral health services for members via RBHA referral and or primary care physician setting and follow up to ensure engagement.
16	IV. Program Behavioral Health		126	Does the behavioral health contractor coordinate full wrap-around services?	AHCCCS is assuming that the Offeror is meaning the "behavioral health contractor" to be the Offeror. The Offeror is responsible for collaborating with all agencies/organizations to ensure the delivery of behavioral health services. The Offeror may be required to participate in service planning.
17	IV Program Behavioral Health		126	What are the mission and functions of the RBHAs?	Regional Behavioral Health Authority (RBHA's) are contracted with Arizona Department of Health Services (ADHS)/Divisoion of Behavioral Health Services (DBHS) to provide all medically necessary behavioral covered behavioral health services to TXIX and TXXI members. These covered services can be rendered by providers, operating within their scope of practice and are AHCCCS registered providers.

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18	IV Program Behavioral Health		126	What are RBHA's defined roles, responsibilities and relationship with respect to interfacing with the behavioral health contractor?	Please refer to ADHS/DBHS website at www.azdhs.gov/bhs to review RBHA contracts with ADHS/DBHS. ADHS/DBHS contracts with RBHA's for the coordination of care with AHCCCS Acute contractors.
19	IV Program Behavioral Health		126	What is the assessment process for determining who is eligible for full behavioral health wrap-around services?	RBHA's are responsible for determining the medically necessary services for all members including direct and rehab/support services.
20	IV Program Behavioral Health		126	What are the RBHA/s defined roles, responsibilities and relationships with the respect to interfacing with providers?	ADHS/DBHS requires RBHA's to provide diagnosis and prescribed medications to PCP's for all members with SMI and members that are referred by the PCP. RBHA's are responsible for coordinating care with all appropriate providers involved with member care.
21	IV Program Behavioral Health		126	Who is responsible for collecting encounter data for behavioral health services? Will the acute care contractors have access to that data?	Refer to paragraph 12 - Behavioral Health Services. Encounter data collection is the responsibility of the Contractor providing the Behavioral Health services. Contractors do not have access to other Contractor individual encounter data at this time.
22	IV Program Behavioral Health		126	Are the acute care contractors responsible for providing all medications, including anti-psychotics, etc.?	Offerors shall allow PCP's to provide medication management to members with diagnosis of anxiety, depression and Attention Deficit Hyperactivity Disorder (ADHD). Psychotropic medications prescribed by a RBHA staff or contracted provider are the responsibility of the RBHA.
23	IV Program Behavioral Health		126	With respect to the language in question 42 that indicates that PCPs should be educated to be able to treat "ADHD, depression and anxiety behavioral health conditions" please clarify if this relates to providing these services in the context of a Medical Home and not otherwise as a requirement in the contract.	Please refer to Paragraph 12, Behavioral Health Services, Subparagraph titled Medication Management Services for more information on this subject. This language refers to Primary Care Physician's option to provide treatment for depression, anxiety and ADHD in the primary care setting, including the processes for referral to and from the RBHA.

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24	Question 34		143-149	For purposes of completing the Network Attestation document, may an offeror who has sufficient physician coverage to admit to a rural hospital, but no contract or loi, indicate "contracted" on the network <u>attestation document</u> ?	Yes.
25	Data Supplement		Maternity Care	What expenses are supposed to be covered by the Delivery Case rate. That is not the same for all states. It is just the delivery event itself or does it include pre and post <u>natal care</u> ?	See Section R of the Data Supplement for a description of the services covered and related data.
26	Databook and CD			Do the claim payment expenses in the databook and CD include costs paid to capitated physicians?	Yes, if a subcapitated arrangement was reported in the encounter, the AHCCCS allowed amount was used as the health plan paid amount. If AHCCCS Allowed Amount is greater than the Billed Amount, the Billed Amount is used.
27	I		127	Is a response required for question #43 regarding the development of Medical Homes?	No. If the Offeror is not interested in leading the development effort on Medical Home, the Offeror should not respond to this question.
28	I		126	Is the Offeror able to reference all Az. community organizations with whom it is involved, related to quality improvement activities/initiatives, or only as related to the Az. Quality Improvement Organization's initiatives	The Offeror may include any community organizations, including those related to the QIO, that it wishes to in its response.
29	Attachment B		139-140	Under Minimum Network Standards for the non metropolitan Phoenix and Tucson regions; are there specific participation requirements hospital and specialty networks? We are unclear as to the intent of the requirement "Hospitals: Physician(s) w/admit and treatment privileges required in the following communities"	Contractors are required to have in place an adequate network of providers capable of meeting the requirements of this procurement. While contracts with hospitals and specialty networks are not included as submission requirements, Offerors are encouraged to establish contractual relationships with hospitals and specialists. The intent of the Rural county requirement is for Offeror to obtain Contracts or LOI with Physicians with hospital admit and treatment privileges in each of communities listed.

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30	Databook, Data Supplement, Section B – Program Changes		1	AHCCCS indicates that the impact of Hospice in CYE08 is expected to be \$3million. Has AHCCCS excluded any Hospice payments paid for by health plans in the past from their data book (given that this was a non-covered benefit), and what assumptions were made about increasing demand once this benefit is fully covered?	Yes, coverage by health plans while the service was a non-covered service has been excluded from the data. No assumptions were made regarding increasing demand, however AHCCCS believes that some hospice costs may be offset by a decrease in hospital inpatient costs.
31	Databook, Data Supplement, Section B – Program Changes		2	Has AHCCCS truncated/thrown out any outliers from expenditures in the capitation development process?	No, stays that may no longer qualify for outlier are still in the databook data.
32	Databook, Data Supplement, Section B – Program Changes		6	AHCCCS indicates that the outpatient and emergency room payment methodology change resulted in a Statewide 6.4% increase in the outpatient and emergency room categories on a PMPM basis across all prospective risk groups. Was this a straight unit cost adjustment, or a general trend that might include changing mix of services or increased utilization?	The 6.4% was unit cost adjustment.

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33	D	53	75	<p>The TWG population has a disproportionate amount of cost related to acute events, as opposed to the chronic conditions that risk adjustment models like CDPS or ACG's give most weight to. Given that there will be no reconciliation of the TWG costs, and given that the experience of this group has significant variability from year to year, how will AHCCCS have confidence that the rates for this group will be sufficient?</p>	<p>AHCCCS believes that the data and characteristics of the population for the non-MEDs is stable, providing sufficient experience to set an actuarially sound rate. For MEDs, AHCCCS is amending the RFP to include a reconciliation for the prospective MED population. See changes included in this amendment for additional details. A detailed policy regarding the reconciliation will follow in the Bidder's Library. AHCCCS has further determined that we will set the MED rate and the Offerors will no longer be required to bid a rate for the MEDs. The MED rates will be posted in the Data Supplement when available. AHCCCS will update the enrollment mix percentages used to develop the composite capitation rates, found in the Data Supplement Section H - 2, to exclude the MED members. These updated enrollment mix percentages will be posted to Section H as Report 8, by Tuesday March 18. The Bid Submission Tool will be updated, to accommodate the MED change, by Friday March 14. Instructions for handling the MED change in the Bid Submission Tool will be posted to Section F by Tuesday March 18.</p>
34	D	53	75	<p>AHCCCS has referenced a 9% administrative load in the last Q&A response (Question 15). Does this administrative load include a provision for premium tax, or is that an additional factor?</p>	<p>This is strictly administrative load. AHCCCS is amending Attachment C of Amendment #1, answer to question #15 to change this amount to 8.5%. See changes included in this amendment for additional details. AHCCCS will amend the Delivery Supplement Payment rates and SOBRA Family Planning rates found in Sections S and U, respectively, of the Data Supplement.</p>
35	Data Supplement			<p>Why are the reinsurance off sets in GSA 12 increasing so much?</p>	<p>Due to the rebase of the RI offsets and the historical trends for inpatient and RI for GSA 12.</p>
36	Data Book			<p>Were SOBRA-mom related costs excluded by rate code? If so, would AHCCCS please provide the rate codes excluded? If not excluded by rate codes, how were the costs excluded?</p>	<p>SOBRA women are included in the appropriate TANF categories as noted in the introduction to the databook, Section C of the Data Supplement.</p>

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37	Data Supplement & Section B			We request that AHCCCS provide the bidders with the revenue dollars that have been included in the historical encounter data representing the supplemental payments that are to be included in the capitation rates beginning in CYE09. It is not possible to understand the changes in capitation rates from CYE08 to anticipated capitation rates for CYE09 without understanding the impact these supplemental payments will have on individual capitation rates. We need this information by contract year, aid category and GSA.	Revenue dollars are not included in encounter data. The only changes for CYE 09 were to eliminate the hospital supplemental payment which was only paid to the MED risk group and to eliminate the HIV/AIDS Supplement payment. Approximately 95% of the hospital supplemental related costs happen during the PPC time period therefore are included in the PPC MED rate that AHCCCS will set. The remaining approximate 5% of prospective costs are included in the databook data in Section C of the Data Supplement. The costs related to the HIV/AIDS supplement are also included in the data in Section C of the Data Supplement.
38	Data Supplement			Please provide historical capitation rates paid to plans for CYE05, CYE06 and CYE07. Currently bidders only received CYE08 plan capitation rates.	Average Capitation rates for these contract years is available at http://www.azahcccs.gov/RatesCodes/#Cap under Statewide Average Rates.
39	Data Supplement			Please provide the Section J Financial Information Excel workbooks for CYE05.	This information will be provided as an addition to Section J of the Data Supplement by March 14th.
40	Data Supplement			Please provide revenue information in the Section J Financial Information workbooks. We need capitation, delivery supplemental payments and other supplemental payments separately by aid category and GSA.	AHCCCS will add statewide data to Section J of the Data Supplement, when available. If data by GSA is available prior to March 28, that data will be posted as well.
41	D	53	75	Is it AHCCCS's intention to construct the actuarial rate ranges before March 28? Or does AHCCCS intend to consider plan input and finalize the actuarial rate ranges after the bids are received?	Actuarial rate ranges will be calculated without regard to Bidder submissions and will be completed before March 28th.

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42	Data Supplement			What is AHCCCS's opinion on the cause of the high trends observed in both the encounter data and the Section J financials for CYE07? What is causing the double digit trends, especially in IP hospital, ER and Rx?	Based on AHCCCS research and health plan feedback, the higher trends appear to be caused by an increase in admits as well as some seasonality impacts. See also Section C for a trend assumptions.
43	B	Hospice	1	Are the adult hospice encounters that were provided by plans out of their administrative budgets (but not included in cap rates) included in the encounters in the databook?	No, these have been excluded from the databook.
44	Data Supplement			Please provide membership and encounter data for CYE06 split into the first 6 months of CYE06 and the last 6 months of CYE06. The high utilization trends in the first 6 months of CYE07 might be partially explained by seasonality.	See Section C of the data supplement for comments regarding seasonality. AHCCCS has a data request into AHCCCS ISD to provide the databook data as requested. This data may or may not be available prior to March 28th. If available prior to March 28th, it will be posted in Section C of the Data Supplement.
45	I	62 and 66	130	The first round of Qs and As said that bidders cannot refer the AHCCCS reader to another section of the proposal for additional information. In light of this response and the five page limit for question #66, please explain what AHCCCS is looking for in question #66 relative to the member grievance narrative that is different from the response provided for question #62	Question 62 refers to the member grievance process and question 66 refers to the total grievance process.
46	I	46	128	Can you please provide clarification of your expectations for the requested syllabus? Are you expecting that each syllabus include goals, objectives, grading, etc. or does a training agenda/schedule suffice? Also, are multiple syllabi permitted to address the different training schedules for different departments?	AHCCCS will not disclose the scoring and evaluation criteria beyond what has been provided in the document. The Offeror must respond to the submission requirement. Multiple syllabi are permitted.

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47	Section F-Bidders Library			Can you confirm that premium tax is paid on reinsurance receivables?	Premium Tax is paid on reinsurance payments paid to the health plans, not on their reinsurance receivables.
48	Section N			Since the outlier claims disproportionately affect large, reinsurable inpatient claims, did AHCCCS reduce the reinsurance offsets by this same disproportionate amount?	AHCCCS considered the outlier impact on the reinsurance offsets, however it would not be the identical impact due to deductibles and coinsurance.
49	Section N			When AHCCCSA weighted historical large inpatient claims data to project future reinsurance costs, did they use the same weightings that were used for total inpatient data in the base rate?	Similar weightings were used, but due to the longer lag in Reinsurance, AHCCCS used full year CYE06, CYE05 and CYE04 versus 6 months of CYE07, full year CYE06 and CYE05.
50	Section N			When AHCCCS excluded one plans historical data for reinsurance purposes, did they exclude both claim costs and member months?	Yes.
51	Section N			Maricopa's average CYE09 Reinsurance Offset increased 59% over CYE08 for TANF Rate Cells. For just one of many examples, TANF 1-13 CYE09 offset is \$5.31 pmpm which is an increase of 205% over CYE08; however total reins claims (pmpm) for this rate cell were only \$2.62, \$2.47, and \$1.93 in CY04, CY05, and CY06 respectively. Even with very generous trend and completion factors and also conservatively ignoring the significant outlier effect, the reinsurance offset amount is vastly overpriced. Would AHCCCS re-evaluate the CYE09 reinsurance offset pricing so that offerors do not have to increase their bids to make up for these overages?	AHCCCS rebased the RI offsets by using actual encounters that would reach the RI deductible levels considering all plans at the \$20K deductible level. PPC reinsurance amounts were removed from the historical RI data for TWGs and these deductible levels were set at \$20K as well. Due to fluctuations by risk groups from year to year, especially in the smaller GSAs, AHCCCS first set the total GSA RI offsets by taking the historical data and trending this data forward to CYE09 by GSA. Once those GSA RI offsets were set AHCCCS distributed the dollars to the risk groups based on historical risk groups' percentage of RI dollars out of the total RI dollars. The base period used for the RI data and trends was CYE06, CYE05 and CYE04. AHCCCS does not feel any changes are needed to this methodology.

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52	Section N			Can AHCCCS itemize the CYE09 reinsurance offsets by Reinsurance type (Inpatient, Catastrophic, Transplant, Hemophilia, et al)?	This data cannot be provided by March 28th.
53	Section H-4			What base time period are these SFY09 growth projections relative to? Should these percentages be applied to Jan. '2008 enrollment by Rate cell to project SFY09? If the base period has not been provided, can AHCCCS provide their actual Member month projections for SFY08 and SFY09?	The base period is SFY08 for the data in H-4. See Section H-7 of the Data Supplement for member month projections by contract year.
54	Section N			Can individual offerors waive all reinsurance if the offset is prohibitively high? If so, doesn't this fundamentally flaw the average risk pool of plans remaining in the reinsurance program?	No, an Offeror cannot waive reinsurance.
55	Section N			Were the plans that opted not to buy down to \$20k inpatient reinsurance used to price the \$20k reinsurance offset? If so, wouldn't there claim experience be better-than-average and thus skewing the pool of claims used for setting the \$20k reinsurance levels be too high?	Encounter data was used to price the reinsurance offsets by calculating all eligible encounters as if their plan was at the \$20k level
56	Section N			Even with the corrected member months in the reinsurance history the CYE09 reinsurance estimates are too high. Can AHCCCSA re-review their methodology? If they still feel it to be adequate, can AHCCCSA provide more detail on the CYE09 reinsurance pricing?	See answer to Question #51.
57	Section N			Can AHCCCSA provide their completion factors used for reinsurance offset pricing?	See introduction to Section M of the Data Supplement

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58	Section N			Just as AHCCCS provided their estimates of the outlier impacts on total inpatient claims, can they provide their estimated impact of the outlier change on just reinsurable inpatient claims? Aren't the majority of reinsurable inpatient claims outlier claims? If so, wouldn't the outlier change significantly reduce reinsurance?	See answer to Question #48.
59	Data Supplement Instructions			Are the financial reports provided net or gross of TPL/COB?	It is not possible to answer this questions without detail on the specific financial reports in question.
60	Section R			Since C-Section rates have continued to rise, what C-section rate did AHCCCS use in the development of the maternity supplemental payment?	AHCCCS used rates consistent with the information provided in Section R of the Data Supplement for C-Section vs. Vaginal deliveries, with appropriate trends applied. These rates are based on historical encounter data.
61	Section N			If AHCCCS' CYE09 reinsurance pricing is correct, this implies that inpatient claim trend is significantly high. Was this factored into the rate range development?	See Section C of the Data Supplement for discussion on trends.
62	Question 32		126	Does question 32 pertain only to children with special health care needs or to adults as well, (e.g. behavioral health)?	The submission requirement includes "children with special health care needs and other hard-to-reach populations....."
63	D	38		Please clarify that timeliness standard will be monitored by individual form type (Dental/Professional/Institutional) and not all claims combined.	Correct, timeliness standards will be monitored by individual form type.
64	Data Supplement (Section A)			How are claims that fall under catastrophic and transplant reinsurance handled in the data book? Does the data book only include the amount the plan must pay or does it include the entire amount? Do the reinsurance offset PMPMs include an amount for catastrophic and transplant reinsurance?	Encounter data in the databook represents what the Contractor paid. Reinsurance offsets include all reinsurance components, prospective, catastrophic, transplant, etc.

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65	Data Supplement (Section A)			Assume a health plan contracts with a provider at a capitated amount. How are such claims priced in the data book? Are these claims priced at the AHCCCS fee schedule?	See answer to question #26.
66	Section D	2	75	The RFP states that AHCCCS FFS schedule pricing adjustments will be provided. Please direct us to where historical and future rate changes to the AHCCCS fee schedule are located.	Historical fee schedules may be found on the AHCCCS website at http://www.azahcccs.gov/RatesCodes/ . See Section C of the Data Supplement for discussion on future trends.
67	Reinsurance Offsets (Section N)			Will AHCCCS risk adjust the reinsurance offsets?	AHCCCS will meet with Contractors during the contract year prior to the implementation of the risk adjustment methodology to address.
68	Program Changes (Section B)		7	What criteria will AHCCCS use when determining if a member's claims should be used for risk adjustment (for example, if a member has only 6 months of experience)?	AHCCCS will meet with Contractors during the contract year prior to the implementation of the risk adjustment methodology to address.
69	Program Changes (Section B)		7	Will the plan's risk adjustment factors (either based on diagnosis or demographics) be applied to the plan's submitted capitation rate or some normalized capitation rate?	AHCCCS will meet with Contractors during the contract year prior to the implementation of the risk adjustment methodology to address.
70	Data Supplement (Section A)			If the Data Book is net of TPL/COB, are we expected to add an estimated amount of this back into the bid rates and then take it back out on the line "Third Party Recoverables" of the bid or can we just use the data net of TPL/COB and put in zero for the Third Party Recoverables?	Either way is permissible.
71	Program Changes (Section B)		1	We assume that services for HPV are in the Other Professional category of service. Is this a correct assumption? If not, please identify which service category HPV services fall under.	These costs were included in the PCP line.

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72	Program Changes (Section B)		1	We assume services for Hospice are in the NF and Home Health Care category of service. Is this a correct assumption? If not, please identify which service category Hospice claims fall under.	Yes, this is a correct assumption for rate setting purposes. To be clear, Hospice services are not included in the Databook.
73	Attachment G		163	Is it correct to say the only impact to an incumbent health plans' auto assignments, related to enrollment considerations for new and small contractors, will be during the months of October 2008 thru March 2009?	The auto-assignments assigned to a plan will be impacted by the Conversion Group assignment effective October 1, 2008 and any enhanced auto assignment during the months of October 2008 and through at most March 2009.
74	I	Q1	121	Question 1 requires the Plan to submit 3 CDs. Is that a total of 3 CDs or 3 CDs per binder? Where are the 3 CDs placed?	Three CDs in total must be submitted as the answer to question 1 and placed in the Original binder.
75	I	Q1	121	Network Attestation – The lack of shading for Williams and San Luis in the hospital column seems to imply there are hospitals in those cities, is this an error?	Please see the response to question #3.
76	I	Q3	122	Can the answer to question 3 include a one page attachment that provides various statistical and numerical information about the network if including the attachment would cause the answer to exceed the 3 page maximum?	The response may include attachments however, the total number of pages submitted can not exceed the three page maximum.
77	G	Q #4	108	Does the question apply to members of the Health Plan or employees of the Health Plan?	Both

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78	Data Supplement Document M and Document N			<p>The reinsurance offsets for CYE09 appear to be higher than what would be expected by analyzing the historical payments provided in the databook. In some cases, they are significantly higher. For example, the GSA 12 TANF<1 \$20,000 deductible reinsurance payment PMPM for CYE06 was \$54.05. The CYE09 \$20,000 reinsurance offset for this same cell is \$115.69. This gives a leveraged annual trend of 29% which would imply about a 14% or 15% underlying annual claim trend. In order to produce a bid rate that supports this level of reinsurance offset, we would need to assume an unreasonable annual claims trend rate. Does AHCCCS have additional information to support the significant increase in reinsurance offsets? In addition, the GSA 2 TANF<1 \$20,000 deductible reinsurance payment PMPM for CYE06 was \$52.49. The CYE08 \$20,000 reinsurance offset for this same cell was \$94.41. The offset then drops for CYE09 to \$68.76. What additional information does AHCCCS have to support this type of change to the reinsurance offset?</p>	<p>See answer to Question #51 for the methodology. For your specific example above, AHCCCS is seeing double digit PMPM trends in hospital inpatient for TANF < 1 for GSA 12 and will allow those to flow through in the pricing. However, for GSA 2 the trends AHCCCS is seeing are not double digit, they are negative. Thus, this is the reason that GSA 2's TANF < 1 offset decreased and TANF < 1 GSA 12's offset increased.</p>
79	Attachment B		141	<p>Is there a reason why Gilbert Hospital is not listed on Page 141 of the RFP as a District 4 Hospital?</p>	<p>Gilbert Hospital was not added to District 4 due to the number of members residing in District 4 and the size of the facility. However, Offerors have the ability to contract with this facility.</p>